NJDOH *Borrelia miyamotoi* Investigation Worksheet **CDRSS #:**

PATIENT DEMOGRAPHIC INFORMATION

Last Name	First Name	Middle Initial	Date of Birth	Gender
			____/ _____/_____	☐ Female ☐ Male ☐ Unknown

Address:	City	State	Zip Code	Telephone Number
				( ) -

Ethnicity:	Race:		
☐ Hispanic/Latino	☐ Asian	☐ Black/African American	☐ American Indian/ Alaskan Native
☐ Not Hispanic/Latino	☐ White	☐ Unknown	☐ Native Hawaiian/Pacific Islander

SYMPTOM INFORMATION

Symptom Onset Date: ____/____/____	Diagnosis Date: ____/____/____	Provider Diagnosis:

Fever: ☐ Yes ☐ No ☐ Unknown	If "Yes", what was highest temperature? °F/°C
	If "Yes", was fever relapsing? ☐ Yes ☐ No ☐ Unknown

LHD NOTE: If the HCP is unable to provide information about whether there was a history of fever, please contact the patient.

Headache:	☐ Yes	☐ No	☐ Unknown	Abdominal pain:	☐ Yes	☐ No	☐ Unknown
Chills:	☐ Yes	☐ No	☐ Unknown	Anorexia:	☐ Yes	☐ No	☐ Unknown
Night sweats:	☐ Yes	☐ No	☐ Unknown	Dyspnea:	☐ Yes	☐ No	☐ Unknown
Myalgia:	☐ Yes	☐ No	☐ Unknown	Erythema migrans rash:	☐ Yes	☐ No	☐ Unknown
Arthralgia:	☐ Yes	☐ No	☐ Unknown	Dizziness:	☐ Yes	☐ No	☐ Unknown
Fatigue:	☐ Yes	☐ No	☐ Unknown	Confusion:	☐ Yes	☐ No	☐ Unknown
Nausea:	☐ Yes	☐ No	☐ Unknown	Photophobia:	☐ Yes	☐ No	☐ Unknown
Vomiting:	☐ Yes	☐ No	☐ Unknown	Vertigo:	☐ Yes	☐ No	☐ Unknown
Diarrhea:	☐ Yes	☐ No	☐ Unknown	Meningoencephalitis:	☐ Yes	☐ No	☐ Unknown

Other symptoms (please describe):

CLINICAL INFORMATION

Leukopenia:	☐ Yes	☐ No	☐ Unknown	Thrombocytopenia:	☐ Yes	☐ No	☐ Unknown
Neutropenia:	☐ Yes	☐ No	☐ Unknown	Elevated liver enzyme levels:	☐ Yes	☐ No	☐ Unknown

Does the patient have any underlying immunosuppressive illnesses? ☐ Yes ☐ No ☐ Unknown

If "Yes", please describe:

Did patient die from their illness? ☐ Yes ☐ No ☐ Unknown	Was patient hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital Name:	Admit Date:	Discharge Date:

DIAGNOSTIC LABORATORY INFORMATION

Please send a copy of any laboratory results, including co-infections, to NJDOH along with this completed case report form

Borrelia mayonii	☐ Positive	☐ Negative	☐ Not Done	Ehrlichiosis	☐ Positive	☐ Negative	☐ Not Done
Anaplasmosis	☐ Positive	☐ Negative	☐ Not Done	Lyme Disease	☐ Positive	☐ Negative	☐ Not Done
Babesia	☐ Positive	☐ Negative	☐ Not Done	Other:	☐ Positive	☐ Negative	☐ Not Done

TREATMENT

Name of Antibiotic(s)	Dosage and Duration	Dates of Treatment
☐ Doxycycline		____/____/____ to ____/____/____
☐ Other antibiotic		____/____/____ to ____/____/____
☐ Not treated		

EXPOSURE INFORMATION	
In the 30 days before the illness onset date, did the patient:	
Have a history of a tick bite? ☐ Yes ☐ No ☐ Unknown	Travel outside of New Jersey? ☐ Yes ☐ No ☐ Unknown
If "Yes", date of bite:	If "Yes", dates of travel: ___/____/____ to___/____/____
If "Yes", town where bite occurred:	If "Yes", travel location(s):

ADDITIONAL COMMENTS

PROVIDER INFORMATION	
Provider Name	Telephone Number **( ) -**
Provider Address	Fax Number **( ) -**

Please fax completed investigation worksheet to the New Jersey Department of Health at: **(609)- 826-4874**

OR

Local Health Department

Address _____

Attention _____

Telephone # _____ Fax # _____